CCS CORRECT CARE SOLUTIONS

Clinic

HEALTH SERVICE REQUEST
SOLICITUD DE SERVICIO DE SALUD

1E-14

NAME (NOMBRE) Olisant Scott

Date of Request (Fecha de solicitud) 9-23-16.

ID # (Nº de identificación) [redacted]

DOB (Fecha de nacimiento) [redacted]

Site (Sitio) ______

Unit (Unidad) E1-14

Nature of Problem or Request (be specific) Naturaleza del problema ó solicitud (sea específico): I've had issues with cyst in Breast @ the present time I have a swollen right breast which it appears to be a knot the size of a baseball. Need attention a soon as possible.

List Allergies (Nombre las alergias): ______

I consent to be treated by Health Care Staff for the condition described (Doy mi consentimiento para que la condición descrita sea tratada por el Personal de Asistencia Médica). I understand that the following co-payments apply: Medical Doctors visit ($12.00), Dental visit ($10.00), Medication & Refills (medical, dental, psych) ($5.00 each), Pregnancy test ($12.00) and Weight check request ($12.00). Medical treatment will never be refused regardless of my ability to pay.

Very Hard Lump Rt Breast at 9 o'clock area

Olisant Scott

Inmate Signature and Date (Firma y fecha del recluso)

THIS FORM MUST BE HANDED DIRECTLY TO A NURSE

ESTE FORMULARIO DEBE SER ENTREGADO DIRECTAMENTE A UNA ENFERMERA

97.6

Do Not Write Below This Line

5/11

Received/Triage Date: 9-23-16 Time: 2100 Signature: [signature]

Refer to: ___Provider ___Nursing ___Dental ___Administrator

Nurse Signature: ______ Date/Time [redacted]

Nurse Practitioner
Correct Care Solutions/OCJ

#10.48

HEALTH CARE DOCUMENTATION

Response to Inmate: See Female NPW

R. Brest is swollen and red — warm. 6x6 inches H/O case in (L) breast in 2010 or 11 went to hospital had it removed.

Start Friday 8/10

Allergies ⊘ 120/80 124 97.6 98%

Nurse Signature: ______ Date/Time ______

Bactrim 2- Wed. HCPSC 9/28/16

BID

Motrin

Inmate Name	ID#	DOB	Date

CCS-SC01es 800 revised 7/1/09 NOTE: This is a 2-part form

CCS CORRECT CARE SOLUTIONS

HEALTH SERVICE REQUEST
SOLICITUD DE SERVICIO DE SALUD

IE147

NAME (NOMBRE): Olimant Scott   Date of Request (Fecha de solicitud) 10-1-16

ID # (Nº de Identificación) [redacted]   DOB (Fecha de nacimiento) [redacted]

Site (Sitio) ______   Unit (Unidad) ______

Nature of Problem or Request (be specific) Naturaleza del problema o solicitud (sea especifico): Ive tried being patient but the pain that I'm feeling is so bad. This piel or whatever it is. Is not helping any. It's not fair that I have to sit here day after day in so much pain. I need something else ASAP. This is not something minor!!! and can I have Ice or heat.

List Allergies (Nombre las alergias): NON

I consent to be treated by Health Care Staff for the condition described (Doy mi consentimiento para que la condición descrita sea tratada por el Personal de Asistencia Médica). I understand that the following co-payments apply: Medical Doctors visit ($12.00), Dental visit ($10.00), Medication & Refills (medical, dental, psych) ($5.00 each), Pregnancy test ($12.00) and Weight check request ($12.00). Medical treatment will never be refused regardless of my ability to pay.

[signature]
Inmate Signature and Date (Firma y fecha del recluso)

THIS FORM MUST BE HANDED DIRECTLY TO A NURSE
ESTE FORMULARIO DEBE SER ENTREGADO DIRECTAMENTE A UNA ENFERMERA

Do Not Write Below This Line

5/4

Received/Triage Date: 10-1-16   Time: 10   Signature: [signature]

Refer to: ___**Provider** ___**Nursing** ___**Dental** ___**Administrator**

Nurse Signature: 3634   Date/Time ______

HEALTH CARE DOCUMENTATION

Response to Inmate:

US ordered. on motrin
Reviewed and informed & K work NP

offered ice packs IM stated
"NO I DONT NEED IT"

[redacted]
... Nurse Practitioner, FNP-C
Correct Care Solutions/OCJ

Nurse Signature: ______   Date/Time ______ [signature]

Inmate Name	ID#	DOB	Date

CCS-SC01es 600   revised 7/1/08   NOTE: This is a 2-part form

CCS CORRECT CARE SOLUTIONS

HEALTH SERVICE REQUEST
SOLICITUD DE SERVICIO DE SALUD

NAME (NOMBRE) Alisa ... Date of Request (Fecha de solicitud) 10/7/16

ID # (Nº de identificación) [redacted] DOB (Fecha de nacimiento) [redacted]

Site (Sitio) 14 Unit (Unidad) E1

Nature of Problem or Request (be specific) Naturaleza del problema o solicitud (sea específico): I need more pain pills. Motrin 600-800mg 1-2x a day that helps me also. I believe right breast is now infected. It's been over 2 weeks. I'm in pain + no one is helping. This is sad. I was told that I should have been seen by doctor. Only Nurse Practitioner saw me

List Allergies (Nombre las alergias): ______

I consent to be treated by Health Care Staff for the condition described (Doy mi consentimiento para que la condición descrita sea tratada por el Personal de Asistencia Médica). I understand that the following co-payments apply: Medical Doctors visit ($12.00), Dental visit ($10.00), Medication & Refills (medical, dental, psych) ($5.00 each), Pregnancy test ($12.00) and Weight check request ($12.00). Medical treatment will never be refused regardless of my ability to pay.

Inmate Signature and Date (Firma y fecha del recluso)

THIS FORM MUST BE HANDED DIRECTLY TO A NURSE
ESTE FORMULARIO DEBE SER ENTREGADO DIRECTAMENTE A UNA ENFERMERA

Do Not Write Below This Line

Received/Triage Date: 10/07/16 Time: 1100 Signature: ______

Refer to: ___**Provider** ___**Nursing** ___**Dental** ___**Administrator**

Nurse Signature: ______ Date/Time______

8014 Com

HEALTH CARE DOCUMENTATION

Response to Inmate:

0800 - out @ hospital 10/8/16 ...

10/9/16 out to hospital ... will be seen in HCP sick call upon return

Nurse Signature: ______ Date/Time______

Inmate Name	ID#	DOB	Date

CCS-SC01ed 600 revised 7/1/09 NOTE: This is a 2-part form